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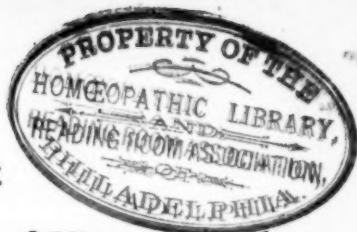
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THE
New York Journal of Homœopathy.

Vol. I.

MARCH, 1873.

No. 1.

ORIGINAL ARTICLES.

THE ANATOMY, PHYSIOLOGY, PATHOLOGY, AND
PSYCHIA OF THE CRANIAL NERVES.

BY J. A. CARMICHAEL, M. D.,

Professor of Anatomy in the New York Homœopathic Medical College.

I. THE OLFACTORY NERVE.

Since their discovery, the cranial nerves have been a prolific source of scientific discussion, and no little contention, in the advancement and progress of medicine. In their early history, they were confounded with the tendons and ligaments, under the name of white tissues, but were distinguished from those parts by Herophilus and Galen. Subsequently, they were divided into cerebral or cranial, Rachidian or spinal, and the Great Sympathetic or Ganglionic system of Nerves, each division presiding over the functions of animal and of organic life respectively. The necessity for a special nomenclature, enumeration and location of the cranial nerves particularly was soon felt, and, as usual with co-laborers in the same scientific direction,—among whom may be found the names of many distinguished in the history of the classical and scientific world, viz., Marinus, Achillini, Massa, Willis, Soemmering, Malacarne, Bichat, Vicq d'Azyr, Winslow, Reil, and a host of others,—a discrepancy arose as to these features in the arrangement of the cranial nerves, to terminate finally in the general adoption of Willis' classification and distribu-

tion of these agents, so important in the dissemination of that subtle and mysterious influence which has been denominated nerve-power. To Willis' arrangement have been subsequently superadded the wonderful discoveries of Sir Charles Bell, and Magendie, in relation to the excito-motor and respiratory nerve-centres, with the numberless facts and lessons of practical utility deduced from them, and which have since been employed in the prevention and cure of diseases hitherto deemed irremediable.

In the necessarily circumscribed space permitted in a medical journal, it would be impracticable to give an extended consideration to the different phases in the history of the cranial nerves as indicated by the caption of this article. I shall therefore confine myself to the most salient and interesting facts and phenomena connected with them, and propose such others as may be considered important, and, hitherto, so far as I have been able by diligent inquiry to learn, novel and unnoticed.

As respects the anatomy of the first pair of cranial nerves—the olfactory, of Willis—it may be dismissed with a few words: and here occurs another instance of the discrepancy existing in the minds of observers, respecting that portion of the brain from which these nerves take their origin. For example, “the old anatomists did not regard them as nerves, but as prolongations of the brain, calling them processus maxillares or carunculæ, and believing them to be intended to drain off the mucosity of that organ.” Others considered them as the representatives of the “olfactory lobes” of the lower animals. Then came the more modern difference of opinion as to their apparent and their real origin, some contending that they arose superficially from the cerebrum, having no connection with the deeper portions of the brain; others, as Willis, described them as arising from the medulla oblongata, the corpus callosum; Ridley, the optic Thalamus, Vienssens, Winslow and Monro, from the corpora striata, the Island of Reil, &c. These different modes of origin being accomplished by three roots—an external or long root, a middle or gray root, and an internal or short root.

Having arisen as indicated, the three roots combine together to form a nerve of a peculiarly soft consistence—substantia

gelatinosa—which makes its way to the horizontal or cribriform plate of the ethmoid bone, and there meeting its fellow of the opposite side, each nerve expands into an olive-shaped ash-colored and extremely soft bulb, to which Malacarne first applied the term “Ganglion.” Upon minute examination this bulb is found to consist of white and gray matter, and from its under surface the olfactory filaments are given off, and immediately dispatched and seemingly *pressed through* the foramina of the cribriform plate of the ethmoid bone, a peculiarity of distribution that appertains exclusively to the nerves of special sense, to which much importance may be attached as respects their function, and to which their properties may be largely attributed. By this mode they reach the upper portions of the nares, and are distributed by numerous fibrillæ upon the roof of the nose, the septum, and the superior and middle turbinated bones. I have thus endeavored, as briefly as possible, to describe the anatomy of the olfactory nerve, and proceed now to the consideration, of the second feature in its history, viz., its physiology.

In discussing the Physiology of this nerve, I shall endeavor to show that it owes its specific properties, primarily, to its organic constitution; secondly, to its mode of distribution, and thirdly, to certain other nervous associations to be found within the cavities of the nostrils.

The organic constitution of the olfactory consists of a compound—*substantia gelatinosa*—triple in its character, and which seems to be a contribution from the two organic elements of brain-matter, cineritious and medullary, with the superaddition of a material ganglionic in its nature, and hence the denomination “Ganglion of the Olfactory Bulb,” as applied by Malacarne, and accepted by Scarpa and others. From this circumstance alone, and consistently with the universally recognized deductions of Sir Charles Bell, of more modern authority, respecting the compound powers of nerves inheriting these elements in their organic nature, we are warranted in concluding—1st, that the olfactory nerve is endowed with multiple power, because of its triple organization; 2d, that each olfactory fibrilla possesses a specific senso-graphic individualism or capacity of appropriation of an odorous emanation in special affinity with it, and that by the combi-

nation of these powers, we are enabled to receive, accept and individualize each fragrant wave that shall undulate in grateful and aromatic exhalation upon the olfactory sense, ever waiting to receive it and repeat it to the great nerve-centres hidden deeply and securely within the penetralia of the brain.

In confirmation of the multiple power of the olfactory by reason of its compound organization, we have only to reflect upon the complex powers enjoyed by the Pneumogastric, one of Willis' eighth pair. This wonderful nerve, called Vagus the Wanderer, because of its intricate and mysterious windings through those organs, so various in character and function, which it is destined to supply with its many and subtle influences, as it passes on its devious way to its final termination upon the stomach, is a remarkable and familiar example of compound nerve-power derived from the organic centres, and entrusted to individual nerves.

Let us briefly recall some of these properties. Soon after its exit from the cranium, the Pneumogastric manifests a ganglionic enlargement of its substance, dispatches filaments of communication with surrounding nerves by which sensation and motion are bestowed. It then unites with the sympathetic and Glosso-Pharyngeal to form that remarkable plexus, the Pharyngeal Plexus, by which a special sense is bestowed upon the pharynx, viz., the sense of thirst; by which the instinctive power of deglutition is enforced; by which hysteric, tetanic, hydrophobic, and other convulsive phenomena are made to appear. It next gives sensor and motor power to the larynx—the first, to protect this delicate organ from offending and hurtful objects; the second, to insure the rythmic regularity of the access of air to the lungs, and the necessary and beautiful modifications and changes in the apparatus or instrument by which vocalization is perfected. It then proceeds to give life and animation to the heart and lungs, by which these organs are constantly stimulated to the proper performance of their functions; and ends its beneficent ministrations by superintending and facilitating the digestion of food for the nutrition of the body, and thereby resisting the constant tendency to decay and death which belongs to all things mortal.

Now all these properties of the Vagus are due to its com-

pound organization, and its heritage of the powers resident in the materials of which that organization is composed. I might here, with advantage, advert to the interesting discoveries and experiments upon primitive nerve-cells, nuclei and nucleoli, by Vauquelin, L'Heritier, Gerber, Purkinje, Remak, Virchow, Grohe, Waldeyer, &c., but want of space forbids.

If, then, it be consented to attribute these various powers to the Vagus, because of its organization, shall it be considered inconsistent with the inexorable requirements of physiology, to refer to the olfactory impulses of a kindred nature, though subject to different laws, and manifesting themselves in a different way?

Again, I have advanced the opinion that each olfactory nerve fibrilla possesses a senso-graphic individualism, or capacity of appropriation of an odorous emanation in special affinity with it, by which it receives and transports its impression to the sensorium. For some years past I have been accustomed in my lectures upon the anatomy and physiology of the auditory nerve, one of Willis' seventh pair, to describe the columnar form in which the auditory nerve fibres are arranged in the recesses of the labyrinth of the ear, and to express my belief that, as these fibres differed in length and size, so each one was the special recipient of a given sound, and of that sound alone, like the strings of a musical instrument, for example; and that the capacity for receiving and appropriating various sonorous impressions at the same moment was due to this columnar arrangement of the auditory nerve fibres. My surprise may then be judged, when, on reading some extracts from a scientific lecture by Prof. Tyndall, delivered in London during the past year, the same idea of the columnar form of this nerve was expressed, and claimed to be original, by this distinguished savant. Were it necessary, "a cloud of witnesses," my former pupils, could be summoned to testify to the accuracy of what I have here stated, respecting my early teaching of the physiology of audition. May we not, then, reasoning by analogy, be justified in clothing the olfactory with similar powers of individual senso-graphic appropriation, and ascribe to it such properties as the consent of the physiological world accords to the seventh and eighth pairs of cranial nerves.

Of the pathology of this nerve, I shall offer but few observations, and they shall principally consist of a resumé of the recent experiences of certain of the German pathologists.

In the *Jahresbericht über die Leistungen und Fortschritte in der Gesammten Medicin*, Notta reports twenty-four cases of anosmia, or loss of the sense of smell, and gives the various causes by which it was produced. In some, the absence of the faculty was congenital, being occasioned by the absence or want of development of the olfactory nerve, its destruction by abscess, the pressure of tumors, &c., wasting of the nerve from age, seen also where there was no morbid change and no apparent cause. He mentions the case of a soldier whose duty it was to superintend the cleaning of a sewer, and in whom complete anosmia was produced by the putrid exhalations to which the olfactory was exposed. What he denominates traumatic anosmia, may be produced by concussion of the brain without fracture. Of this he cites instances, and states that the faculty was restored at a later period. Taste and hearing were lost or impaired at the same time. Anosmia was also produced by amputation of the nose, which occasioned an unnatural dryness of the membrane lining the nostril, the olfactory sense returning upon the artificial restoration of the organ. Another cause of anosmia was the contraction or occlusion of the nostrils by nasal polypi. Chronic coryza and catarrh are also prolific sources of it. Wine-tasters retained the power of appreciating the flavors of different wines and fruits, although the sense of smell was lost. In the same journal other cases are reported, by Ogle, of anosmia from falls upon the head, twice upon the occiput. He thinks that the delicate fibrillæ of the nerve were ruptured as they entered the ethmoidal foramina. In all cases the patients complained of loss of smell and taste, except for the radical qualities of sweet, sour, salt and bitter substances. There was no appreciation of delicate flavors or odors. Facial paralysis, by preventing due dilatation of the nostrils, he cites as another cause; also thickening of the membrane, from chronic coryza interfering with free inspiration, though permitting expiration; adhesion of the velum to posterior wall of pharynx, whereby nasal respiration was prevented. Anosmia and aphasia were also observed simultaneously. The anterior

root of the olfactory arises from the Island of Reil, and hence lesion of the brain at this point might produce the two phenomena. In the case of a negro who became gradually white, or nearly so, and in whom was observed an increasing anosmia, Ogle did not consider it a mere coincidence, but endeavors to establish the fact that the pigment of the receiving surfaces of the nasal passages is of essential functional importance in the sense of olfaction, and that both comparative and ethnological anatomy tend to substantiate this fact. White herbivorous animals are more frequently deceived in the choice of food than dark. In this way, too, may be explained the greater absorption of odors in the dissecting room by dark clothes. The experiments of Murchison and Dumeril upon the absorption and conveyance of typhus, tend also in the same direction, &c.

THE PSYCHIA OF THE OLFATORY NERVE.

By this term I propose to indicate the psychical, or emotional, influences exercised by the olfactory sense. For the perfection of this property of the nerve, it depends, not only upon its own intrinsic organization, but upon certain other nervous associations, which have been elsewhere briefly adverted to. In order to facilitate our investigation in this direction, let us recall the anatomy here.

Within the cavities of the nose are found, not only the olfactory nervous distribution, but also certain contributions to its lining membrane derived from the "Trigemiums"—fifth pair of Willis—its ophthalmic division, and from the great sympathetic ganglionic centres, by means of Meckel's ganglion Spheno-palatine. From its ophthalmic division, the trifacial sends a branch—the nasal—which enters the orbit between the two heads of the external rectus muscle of the eye, passes obliquely inwards, across the optic nerve, to the inner wall of the cavity, enters the anterior ethmoidal foramen, by which it gains access to the cavity of the cranium, then traverses a groove on the cribriform plate of the ethmoid bone, and passes down through a slit by the side of the crista Galli into the nose, where it terminates by ramifications upon the nasal lining membrane. The sympathetic or ganglionic contributions are, as before stated, from Meckel's ganglion, the largest

of the cranial ganglia, and are equally distributed upon the nasal cavities. From the arrangement of the olfactory sensographic fibrillæ, as well as from their organization, I have endeavored to establish the multiple character of its appropriating power, and now propose to increase it by its associations with the additional nerve-force derived from the trifacial and sympathetic. The trifacial nerve-force has been amply established by the experiments of Sir Charles Bell, Magendie, and others, as being composed of sensor and motor influence—the former derived from its ganglionic attributes, the latter being the inherent property of the nerve because of its medullary character. The motor influence is necessarily expended where it legitimately belongs—the muscles; the sensory, upon the receiving surfaces to which it is applied. Most prominently among these surfaces is the nasal membrane, and to it the nasal nerve transmits its inherent sensific powers.

Let us analyze these powers. And it would seem that while the senso-graphic olfactory fibrillæ are the recipients of all the gentler aromatic influences, such as the fragrance of flowers, manifesting itself in intoxicating and entrancing forms, and in such Protean and endless variety; and while from their delicate texture, they naturally shrink from the rude mildew of noisome and putrid exhalations, and find their true mission in receiving and bestowing grateful and pleasing sensations, the nervous distribution of the trifacial, by its nasal branch, is manifestly for the double purpose of giving general sensation to the membrane lining the nostrils, whereby it is maintained in a condition of general olfactory integrity, and also for the reception of the more pungent odors, thus giving warning to the delicate senso-graphic fibrillæ of the olfactory nerve, and affording protection against pernicious and destructive odorous invasion. But the true *psychia* of the olfactory nerve is found in its sympathetic connections, and to these I would now, in conclusion, especially invoke attention.

By the association existing between the olfactory sense and the ganglionic or sympathetic system, through the media above designated, there is established a link in the great chain of emotions, sympathies and affections. Do we not recognize the impulse of these sympathies at every moment of life?

I will first consider those of a grosser character. When a repulsive odor assails the nostrils, it is conveyed by means of the various links in the chain of nervous sympathies and connections. The stomach responds to the disturbing agent, nausea supervenes, often followed by emesis, and a sensation of general disgust prevails. In the same way may we account for those peculiar idiosyncrasies which are frequently met with, viz., the inability in some individuals to inhale certain odors without experiencing a sensation of faintness, accompanied with diminished cardiac action, and consequent pallor, so that "to die of a rose, in aromatic pain," may not necessarily be a figurative expression, or a poetic license. Again, certain odors are suggestive of gloomy subjects; as, for example, the odor of the tuberose, which, to many, invariably recalls the funereal paraphernalia of death.

But let us take a more cheerful and pleasing view of these olfactory emotions and sympathies. When the aroma of a familiar and favorite flower falls upon the senso-graphic nerve-fibre, what is it that makes the eye brighten, or, it may be, become lustreless and dim from the unbidden tear, the cheek to flush high with hope, or pale with painful reminiscence, the heart to beat with quickened pulse, and the bosom to heave responsively to the unwonted emotion? Why do we thrill at the proximity of a loved object, and why does the odor exhaled from the person of that object, which to the lover is sweeter than all "the perfumed gales of Araby the blest," still urge him by its sweet and subtle influences? And even when in dreams we recall the loved and lost, how often does it seem that a fragrance from unknown and celestial realms is wafted to our exalted and expectant sense? What is it—what can it be—but those mysterious nerve-links, "the electric chain, wherein we're darkly bound?"

[It gives us pleasure to announce that a continuation of these articles will be published in future numbers of this journal.—Eds.]

HISTOLOGY:
THE METHOD OF TREATING IT IN THE NEW YORK
HOMŒOPATHIC MEDICAL COLLEGE.

BY G. S. ALLAN, D. D. S., NEW YORK.

To present the subject of histology in a clear and satisfactory manner to a class of medical students, is by no means an easy task. Many difficulties inherent in the subject itself present themselves, and must be met and overcome in some way different from that ordinarily pursued with medical subjects. Lectures simply are not satisfactory, for no oral description will convey to the mind of a beginner anything more than an indifferent idea of a tissue or structural element. The mind fails to grasp that which it does not see, or cannot compare through the operation of the senses with that which is known and tangible. The whole subject is in many respects a new one, and is inseparably linked with an instrument—the microscope, a knowledge of the properties, values and uses of which must necessarily precede the study of the subject itself. The use of the microscope has been likened to the acquirement of a new sense, and the simile is not far-fetched. Though a new sense is not obtained, the domains of the old are so far extended that one finds himself on new mental territory, and new thoughts, ideas and reasonings find a ready expression in the wants of the new science.

As all things are large or small, hard or soft, etc., only by comparison, so the senses must first grasp the standard before the idea can be correctly conveyed. Here it is that we see the trouble of teaching histology. The common measuring-rule is wanting. We can only compare the minute with the minute, and the size, shape and specific characters of tissues can only be made out by means of the microscope. Consequently, at our first step in advance, we encounter a new thing.

Obviously, then, a course of lectures only on the subject, to a class of beginners, would fail to satisfy their wants, and they might also fail to arrest their attention or excite

their interest. The unknown quantities with which their minds would have to deal, would confuse them, and crude impressions only would reward them for their best efforts. That this is in the main true, any one can easily satisfy himself, by inquiring amongst those who have acquired their knowledge of histology in such a manner, viz., by listening to lectures, or by reading. Their conceptions of the subject will be found to be vague, and lacking in point and definiteness. A certain amount of knowledge they will have, but not of an available character. They will be far better able to talk about the subject than to use it. To put it in another form, they will be in the position of a person who has read all about Europe, but never crossed the ocean.

Physicians generally are awakening to the importance of a practical acquaintance with the microscope. They see the aid which it can be to them, and the great value of the discoveries that have been made by it in physiology and pathology is appreciated and acknowledged.

Most medical schools give histology a prominent place in their curriculum of studies, and a distinct chair, in most of them, is devoted to it and allied branches of study.

The occupant of this chair in the New York Homœopathic Medical College, to meet the requirements of the case, proposed the following arrangement, which has been adopted.

The duties of the chair are to consist in giving a course of instructions on the use of the microscope, microscopic technology, and histology. They will embrace: First, a description of the microscope itself; the optical and mechanical principles involved in its construction; their various forms, and consequent advantages and disadvantages—especially those most serviceable to the physician; also the accessory apparatus employed with them. Second, to explain its use and management, and how to keep it in order. Third, to describe the various methods of preparing specimens for examination, and how to preserve them for future use. Fourth, to give short, concise descriptions of the principal histological elements, normal and pathological, and to accompany them by exhibitions of the specimens themselves, or by photographic pictures of them thrown on the screen by

means of the stereopticon. The idea being to make the course as practical as possible; to accustom the students to the sight of the microscope, to seeing it adjusted for use, to looking through it, and to familiarize them with the form, character and structure of the subjects described.

The series of photographs to be used in illustrating were all taken from the specimens themselves, and are therefore faithful representations of them—much more so than any of the cuts so common in text-books. From the nature of the case, they must be enlarged fac-similes—exact copies from nature. When thrown on the screen by means of the oxy-calcium light, they are distinctly visible to the whole class.

As the faculty own the negatives from which the pictures were taken, the students can, at their option, obtain the whole, or any portion of the set. The set numbers fifty in all, and can be obtained for nine dollars. No more valuable outlay of money for histological study can be made. Whoever owns a set has at all times a book of ready reference of the subject, of absolute accuracy.

The set intended for class exhibition are, of course, printed on glass, and are diminished in size—about two-thirds. Those intended for private use are printed on paper, as ordinary photographs are, and then mounted on cardboard, 10x12 inches.

As indicating the range of subjects so treated, and their value, a list of them is herewith given. The intention of the College is to increase them from time to time, as their opportunities and wants indicate.

- Cylindrical Epithelium. W.
- Buccal Epithelium. P. & L., 1-16th.
- Cylindrical Epithelium. W., 1-6th.
- Lymphoidal Cells, from Enlarged Tonsil. W., 1-6th.
- Pigment Cells, Choroid of Kitten. W., 1-6th.
- Ganglion Cells, Cord of Ox. W., 1-6th.
- Medullated Nerve-fibres, Axis Cylinder. W., 1-6th.
- Spinal Cord, Sea Turtle. Gundlach, $\frac{1}{2}$.
- Spinal Cord, Sea Turtle. W., 1-6th.
- Cornea Corpuscles and Nerves, Frog. Wales, 1-6th.
- Perpendicular Section Frog's Stomach. W., 1-6th.
- Small Artery, with Nerve Terminations, Frog's Mesentery. P. & L., $\frac{1}{2}$.
- Small Vein from Frog's Mesentery. P. & L., $\frac{1}{2}$.
- Voluntary Muscular Fibres, Frog. W., 1-6th.

- Capillaries and Involuntary Muscular Fibres, Frog's Bladder. Gund., $\frac{1}{2}$.
 Involuntary Muscles and Nerves, Frog's Bladder. P. & L., $\frac{1}{2}$.
 Ultimate Muscular Fibres. P. & L., $\frac{1}{2}$.
 Voluntary Muscle from Child, with Capillaries. Gund., $\frac{1}{2}$.
 Perpendicular Section Iris of Ox, Gund., No. iv.
 Perpendicular Section Suprarenal, Human. Gund., $\frac{1}{2}$.
 Human Pancreas. W., 1-6th.
 Section through Upper Eyelid of Child, Meibomian Gland. Miller Bros., $\frac{1}{2}$.
 Perpendicular Section Stomach of Rat. Gund., $\frac{1}{2}$.
 Lung of Cat, Carmine Imbition. Gund., No. iv.
 Fibrous Nodule from Lung, with Pigment, Human. W., 1-6th.
 Lung Capillaries. Gund., No. iv.
 Long. Section Bone, Human. Grunow, $\frac{1}{2}$.
 Transverse Section Bone. W., 1-6th.
 Junction of Enamel and Dentine, Human. W., 1-6th.
 Ossifying Cartilage. W., 1-6th.
 Articular, Hyaline, Cartilage. W., 1-6th.
 Long. Section Tendon, Human. Gund., No. iv.
 Transverse Section Tendon, Human. Gund., No. iv.
 Malpighian Bodies, and Convoluted Tubes, Human Kidney. W., 1-6th.
 Kidney Tubes, Young Child. Gund., $\frac{1}{2}$.
 Human Kidney, Vessels. Wales, 1-6th.
 Adipose Tissue. Gund., No. iv.
 Adipose Vesicles, with Crystals Manganic Acid. W., 1-6th.
 Waxy Liver. Wales, 1-6th.
 Enchondroma from Humerus. Grunow, $\frac{1}{2}$.
 Lupus of the Vulva. W., 1-6th.
 Myoma from Uterus. Grunow, $\frac{1}{2}$.
 Fibrocystic Lipoma. Grunow, $\frac{1}{2}$.
 Myxoma from Nares. Wales, 1-6th.
 Epithelial Cancer. W., 1-6th.
 Carcinoma Hepatis. W., 1-6th.
 Chondro Sarcoma. W., 1-6th.

W., 1-6th.—Wales' Immersion 1-6th inch Objective.
 P. & L.—Powell & Lealand.

Gund.—Gundlach.

HEMORRHAGE.*

The means and instruments with which to arrest hemorrhage constitute a topic of grave import to the physician as well as the surgeon, because, in the panic which generally accompanies every case of hemorrhage, and of the uncertain and inopportune times at which bleeding may occur, the nearest

* Being part of a chapter from "A System of Surgery," by WM. TOD. HELMUTH, M.D. This work is now nearly ready for the binder.

medical man is summoned, whether he profess surgery as a specialty or otherwise.

The most fearless and bold operators have more or less dread of those great losses of blood, which may either immediately or secondarily prove fatal to the patient. In fact, in the majority of operations, it is "the bleeding" which is most feared. The fact that in a few moments the life of a human being may pass away with the crimson tide which bursts from an open vessel, causes such occurrence to be regarded with much apprehension; and added to this, the heart-sickening scene presented by a person dying from loss of blood, the horror-stricken faces of bystanders, and the disorder and confusion which are often present on such occasions, have taught us to regard hemorrhage always with certain feelings of anxiety. The appearances presented by a person "bleeding to death" are appalling. The ashy paleness of the face, the pinched nose, the blanched and drawn lips, the icy brow, the clammy skin, the intense nausea, and that hazy vacancy that gradually steals over the eye, together with the absolute depression of all those forces which render us cognizant of the great world without, indicate too plainly that vitality is giving place to death, that the wonderful life-current is rapidly being withdrawn from the organism which it nourished, and that light and life are soon to be extinct.

It is not, therefore, surprising that those men who are supposed to be familiar with the means which will save life when it is threatened from loss of blood, should be regarded with feelings almost akin to reverence, and it is in these times that all the self-possession, knowledge, skill, and mechanical tact will be called into requisition.

Such was the confidence placed in the skill of Ambrose Paré in arresting hemorrhage, that he is said to have infused new life into the French army by his appearance in the midst of a sanguinary contest.

I have in my possession a Treatise on Surgery, written a century and a half ago by Samuel Sharp, a pupil of the renowned Chessel den, and Surgeon to Guy's Hospital.* On

* A Treatise on the Operations of Surgery, with a description and representation of the instruments used in performing them, etc., by SAMUEL SHARP, Surgeon to Guy's Hospital, London.

page 221 he has the following paragraph: "There are in armies a great many instances of gunshot wounds of the arm, near the scapula; but the apprehension of *losing patients on the spot by hemorrhage* has deterred surgeons from undertaking it. Fabricius ad Aquapendente appeared to have such horror of hemorrhage that he recommended all incisions for amputation to be made in mortified, and, therefore, bloodless structures. O'Halloran, speaking of amputation of the leg, alludes to the "*bleeding*" as the most troublesome and alarming symptom, and that most reproachful to the surgeon, "the hemorrhage often proving *fatal* to the patient." Professor Thompson, the preceptor of the distinguished Simpson, thus speaks: "The suppression of hemorrhage and the reunion of divided surfaces are, in every wound, and in every operation, the first and ultimate objects of the surgeon's attention." It is unnecessary to multiply quotations to establish *facts* that are so universally acknowledged, and although by some of the newer means for arresting hemorrhage, the occurrence is deprived of some of its terrors, yet it still remains in every operation to demand the serious attention of the surgeon.

Definition.—By the term hemorrhage is understood the escape of blood from blood-vessels. If this discharge takes place from open surfaces, or from organs communicating with the atmosphere, the simple word "*hemorrhage*" is used. When it occurs within the cavities of the body, we have "*internal hemorrhage*." When the discharge of blood is not very great, and remains beneath the surface, "*extravasation*" is produced. When the blood flows freely and in streams, or is profuse in quantity, we use the term "*active hemorrhage*;" "*passive*" being applied to those slow and irregular discharges, generally emanating from the capillary vessels. When the blood flows "*per saltum*," and is bright red, we recognize the characteristics of "*arterial hemorrhage*," and when it is of darker color and a more continuous flow, the hemorrhage is said to be "*venous*." Let me here, however, remark that an arterial hemorrhage may occur in which the blood does *not* flow "*in jets*." I have seen this in amputations where a vessel—perhaps of the third caliber—has contracted behind muscular or tendinous substances, and

in instances in which a longitudinal incision has been made in the coats of an artery; in the latter instance a portion of the blood passing through the tube, the remaining portion issuing through the opening in the coats. In such cases, which are always more or less embarrassing, the color of the blood, and a knowledge of the anatomical relations of the parts, must chiefly be our guide. Sometimes also there may be an apparent pulsation or "*jetting*" to the stream flowing from a good sized vein, owing to its proximity to a large or pulsating tumor or arterial trunk.

Again, surgeons denominate "*primary hemorrhage*" as that occurring during the performance of an operation; "*intermediary hemorrhage*," so, I believe, designated by Butcher, as that which takes place within a few hours after operative procedure, either from the relaxation of tissues, or the increased power of the circulation as reaction is taking place; and "*secondary hemorrhage*" is that which results from the separation of ligatures, or removal of pins or dressings, which have been used to prevent the primary flow of blood.

Hemorrhages, even extravasations, are always looked upon with apprehension. The gradual flow of blood into the meshes of a tissue is serious. If it takes place within the globe of the eye, it may cause disorganization of the entire ball; if within the cardiac structures, imminent peril results; if within the brain, coma and death may supervene; while the dangers from active, arterial, or venous hemorrhage are well known to every one.

HEMORRHAGIC DIATHESIS. HEMOPHILIA.

It may be well here to remark that some persons are much more prone to hemorrhage than others, and a circumstance still more peculiar is found in the fact that the so termed "*hemorrhagic diathesis*" appears in many instances to be hereditary or congenital. In the medical periodicals, and in our text-books, many very interesting cases may be found, furnishing abundant testimony of the fact.

In those who are afflicted with this peculiar and distressing constitutional defect (whether it be a weakness of the capillary vessels, or a loss of their contractile power, or a dimin-

ished quantity of plastic material in the blood, or other unknown circumstance), a very slight and trivial cause, even a pin scratch, may give rise to a dangerous or fatal loss of blood. The diathesis generally is found among the male sex, and in the earlier years of life, the tendency disappearing toward adult age. When it is acquired, it is usually among the poorer classes, who are ill-fed, with lack of light, pure water, exercise and pure air. There are in this affection many symptoms that are analogous to scrofula and scorbutus, the blood being thin and defibrinated, and the hemorrhage taking place often without any assignable cause. Often it occurs beneath the integument, giving rise to dark purple spots, or those of a slightly reddish hue. I have known an almost fatal hemorrhage occur from the gums of a patient, without any assignable cause. Children have perished from loss of blood consequent upon lancing the gums, dividing the "*frænum linguæ*," excising the tonsils, extracting a tooth, and other minor operations.

Some very remarkable cases, in which several in one family have been afflicted with the hemorrhagic diathesis,* are upon record.

I have lately seen an interesting case, in consultation with Dr. Swan, of New York, in which the infant bled profusely from the soles of the feet, the palms of the hand, the umbilicus, and the back. The complexion was very sallow, and though the child, when born, was apparently plump, it took no nourishment, and died in a few days.

SECTION I.—HEMOSTATICS.

Our object now is, to ascertain the proper means and instruments for preventing or arresting hemorrhage, occurring either during or after surgical operations; or that resulting from injury or accident, or constitutional diathesis.

This we term hemostatics, and we divide it into two departments—natural (A), and artificial (B).

(A) *Natural Hemostatics*.—To the student of physiology and pathology, the active part that nature, even unaided, takes upon herself, to repair her temple and preserve vitality,

* Gross' Elements Path. Anat., pp. 203, 204. Gross' Surgery, vol. I.—"Hemorrhagic Diathesis. BRAITHWART'S Retrospect, No. XXIV., p. 199. DRUITT'S Modern Surgery, p. 305.

is well known. With a wonderful and silent power, she keeps guard over her children in every emergency, driving out the innovator; healing broken bones; repairing tissue; manufacturing flesh; glueing together wounds; and in hemorrhage working "*with all her might*" to save her own from death. On this last point, viz., the method in which natural hemostatics arrests bleeding, experimental pathology has revealed much in the last few years. So long ago as 1731, Petit wrote and published several treatises on this subject, giving, from actual experiment, the manner in which "the two clots" are formed by nature to arrest hemorrhage. The inside clot he called "*bouchon*," the outside "*couvercle*." In 1736, Morand, besides allowing the formation of clots, as proposed by Petit, advanced the idea that, besides this, very important changes took place in the coats of the artery itself. It is rather remarkable that, some years afterwards, Sir John Bell denied this proposition. In 1763, Kirkland made an additional step, by showing that, besides the two clots, and the arterial contractions, syncope or swooning lessened or arrested temporarily the discharge of blood, allowing time for clots to form and organize, or for mechanical interference. And finally, Dr. I. F. D. Jones,* who has given us the best treatise on the subject, has informed the surgical world (which it is very important for us to bear in mind, for the proper understanding of the *rationale* of certain methods now employed in arresting hemorrhage), that for the permanent *arrest* of bleeding, "an effusion of coagulating lymph within its (the artery's) canal, between its tunics, and in the cellular substances surrounding it, is necessary, and does take place. Here are then *four* important means employed in natural hemostatics, and if we call to mind the method pursued by nature in repairing fractures, the internal and external callus, the "temporary" and "permanent," and the removal thereafter of that which is unnecessary, a wonderful similarity in the two processes will be found to exist. Let us suppose that an artery of some magnitude is cut across: almost immediately, both divided ends retract within the sheath, and, by virtue of the elasticity of their coats, *contract*

* A Treatise on the Process Employed by Nature in Suppressing the Hemorrhage from Divided or Punctured Arteries, and on the Ligature, by I. F. D. JONES, M. D.

upon themselves, thus diminishing the caliber of the vessel and necessarily diminishing the stream. The sheath, however, not being nearly so elastic as the arterial tunics, retracts but little, thus leaving a species of cylinder around the vessel, to be filled with coagula, which takes place from

filaments of fibrin, being adherent to its walls; and this is increased by the increased plasticity of the blood as it flows. Vide Fig. 1, which shows the plan of natural hemostatics in a cut artery. *a* is the divided extremity of the arterial tube, rendered conical by contraction; *b*, the arterial sheath vacated by the retracted artery, and occupied by coagulated blood; *c*, the coagulum projecting from the orifice of the sheath. The more slowly the blood passes through the vessel, the more opportunity is offered toward the formation of the *internal* coagulum, which forms *within* the vessel in a long and thin clot,

and if syncope have supervened, the conditions will be much more favorable to the "convercle." "In the meantime," says Jones, "the cut surface of the artery inflames; the *vasa*

vasorum pour out lymph, which is prevented from escaping by the external coagulum." This lymph fills up the extremity of the artery; is situated *between* the external and internal coagula of blood; is somewhat intermingled

with them, or adheres to them, or is firmly united all around to the internal coat of the artery. Fig. 2, after Jones, shows also the plan of natural hemostatics. *a* is the external coagulum, incorporated with the coagulum of the sheath, *b*. The internal coagulum is also seen resting upon the external, and extending to *c*, the first collateral

FIG. 1.



FIG. 2.



branch. These are the processes which we find in natural hemostatics, and the more we examine them, the more will the beauty of the process be appreciated. After hemorrhage is suppressed, the artery, at its extremity, and sometimes up to its first anastomosing branch, becomes converted into a ligamentous cord, and the clots are removed by absorption. Fig. 3 shows: 1. Plan of retracted artery, after section; *a*, the conical, contracted, and retracted arterial tube; *b*, the arterial sheath left vacant. 2. Plan of retracted artery after laceration; *a*, the retracted middle and internal coats of the artery; *b*, the external coat; *c*, the twisted sheath.

FIG. 3.



(B) *Artificial Hemostatics.—Internal Medication.*—Among those hemorrhages belonging to surgery, besides those occurring from accidental causes and the surgeon's knife, are epistaxis, and bleedings from the bladder, and the rectum; and even these, in the majority of instances, fall within the province of the physician, in the same manner as do hemoptysis, metrorrhagia, hematemesis, and post partum hemorrhage. I shall therefore speak of *internal medication* so far as it has power to arrest hemorrhage (surgically so-called), and must confess that it is a very difficult matter to lay especial stress on any medicinal means whatsoever, as in almost every case of hemorrhage some local application is made simultaneously with the internal treatment; or, indeed, if medicated substance is not laid over the bleeding surface, it is covered or bound up with bandages, or cloth, or lint, or cotton, or some other substance, to favor the formation of the clots. When vessels of any magnitude bleed, I would unhesitatingly regard it, not only the height of folly, but an unpardonable dereliction of duty, to rely exclusively on the internal administration of medicine, under the conviction that the bleeding would be arrested. Yet I have been told, though I scarcely credit the fact, that there are physicians who, having a case of such arterial hemorrhage, would neither cover the wound with a bandage, nor ligate a vessel, nor apply a styptic.

In passive hemorrhage, there can be no doubt that our medicines are capable of exercising a beneficial effect. In oozings, after large operations, I have frequently witnessed their excellent results. I do not propose to record in this place what is found in the "Manuals" for "Hemorrhages," or I would write that for hemorrhage *in general* (?) we have asaf., cocc., copaiba, iod., and crocus. Hemorrhages from "*various parts*," canth., and phosph. Hemorrhages "from a newly opened wound," opium. Excessive hemorrhage, antimonium crud., and much of the like. My object is merely to mention those remedies which, internally administered, have beneficial effects in certain forms of hemorrhage, coming under the care of the surgeon. For the record of medical and obstetrical hemorrhages, this place is not the proper one.

Hamamelis will arrest a venous hemorrhage proceeding from varicose veins, and hemorrhage from the mouth and gums, and from hemorrhoids.

Dr. Cushing has seen it suppress hemorrhage after extracting a tooth. Dr. Preston has with it cured hemorrhage from the bowels.

Veratrum viride is one of the best medicines for hemorrhages. In the *Medical Record*, Nov. 1, 1872, a case is recorded of its successful use in secondary hemorrhage after amputation.

Nitric acid, given internally, will arrest a secondary hemorrhage from the lower part of the rectum, after the removal of hemorrhoidal tumors.

Monse's styptic, from twenty to thirty drops in half a glass of water, a tablespoonful every half hour, will arrest an oozing from the medullary canal after a resection of the humerus. I was led to its use in surgery by some remarks of Dr. Malcolm McFarland.

Erigeron I have administered with success in hemorrhage from the bladder, after operations for vesico-vaginal fistulæ, rupture of the perineum, etc. For operations about the lower portions of the rectum, crocus and carbo-veg. are excellent medicines. So far as my own knowledge goes, with the exception of arsenicum and *china*, in those cases where there is great prostration of the vital power, and the blood is thin

and defibrinated, I can speak of no other internal medicines. The alnus rubra, apocynum cann, erechthites hieracifolius and iris, or diadema, are laid down as possessing power over hemorrhage. This is a portion of the field of surgery that presents a wider scope to our school than others, and, no doubt will in future be more thoroughly cultivated; but, as I have before mentioned, the fact that many mechanical agents, from the simple roller bandage to the most complicated styptic compounds, are generally employed, will always embarrass the attempt to assign the proper sphere to internal medication.

(To be continued.)

LACTIC ACID. ($C_3H_6O_3$).

BY T. F. ALLEN, M. D.

This drug has been made, under my supervision, the subject of a large number of provings. Most valuable and reliable effects have been observed upon a large number, and from different potencies. Especially has the class of 1873 been enthusiastic in the investigation, and to the class the drug must be dedicated. The award of a gold medal for the best *original* observations on the action of drugs upon the human organism, has served to attract the attention of a large number to the importance of accurate observation. We may expect that, during the coming year, a large number of valuable provings will be made. Especially may we expect extensive observations on the effects of calabar bean, nitrate of soda, and some other substances.

Before giving a detailed account of the action of lactic acid, I desire to make some general remarks, and call attention to the use of the drug empirically by the old school.

In making investigations into the nature of any drug, it is advisable, indeed, necessary, to obtain it in a state of purity, or unvarying composition. This is especially true as regards artificially prepared substances; while as regards natural substances, the rule should be to obtain them at the period of their highest development, or greatest activity. Certain

native inorganic substances cannot be used in medicine until carefully reduced to a uniform composition; indeed, very few ores or minerals are found of such unvarying composition and freedom from admixture, that they can be used as medicines previous to purification. With vegetables the case is different, since a definite form or species of plant, in its mature state, possesses uniform constituents, and a definite and unvarying action upon the animal system. Organic products are especially subject to change, particularly when they are separated from the living organism, and exposed to fermentive and putrefactive processes.

This tendency to instability is very marked in the group of organic acids, which are often rapidly developed as intermediate forms in the fermentation or decay of organic products. When milk sours, lactic acid is developed. This acid, however, will become in turn transformed into carbonic dioxide and water. In sour milk constant change is taking place, various products are being developed and decomposed at every moment. Again, sour milk itself is of such a varying composition, that it cannot be admitted as an appropriate addition to our *materia medica*.

Lactic acid, however, may be easily isolated, and preserved in a pure state as a pungent and acid fluid. This acid represents the intermediate stage of the transformation of glucose into carbonic dioxide and water.

It has been very interesting to notice the remarkable similarity of the provings to the indigestion caused by eating too much candy, which produces the nausea, distress in stomach, and often, in children, the characteristic gagging, choking cough, of lactic acid. The fact that this acid exists as a necessary ingredient of the gastric juice (which owes its acidity to this acid alone), does not at all impair its power of producing most profound derangement of the human economy, when taken as a drug, since any variation in the normal amount of any physiological element or substance produces drug action. Para-lactic acid is found to be a product of muscle waste, and it may be obtained from muscle by maceration; and para-lactates are found normally in the urine.

This fact is of great importance, in view of recent experi-

ments with lactic acid as a remedy for diabetes. Prof. Cantani, of Naples, viewed diabetes as a disease arising from defective combustion, (Whence comes defective combustion?) depending upon the production of a morbid form of *glucose*, *para-glucose*, which is incombustible, and cannot be transformed into lactic acid, and hence is passed unchanged by the urine, so that the heat of the body must be maintained by combustion of other substances, albuminates or fats, and proposed to supply a combustible agent. He selected lactic acid, as representing an intermediate stage between glucose and carbonic dioxide. This he administered in doses of from seventy-seven to one hundred and fifty grains a day, diluted in from eight to ten ounces of water. His diet rigorous. His results are reported as surprising.

In one of the provings lately made, a student who had been habitually obliged to urinate very frequently, who passed large quantities of water, and was even obliged, not only to urinate between lectures, but often to go out for that purpose during the lecture, immediately on taking the acid, in the thirtieth dilution, passed urine only three or four times during the day.

A great many years ago, Dr. Prout advanced the theory that the abnormal retention or unusual production of lactic acid in the system was the cause of rheumatism. Dr. Benj. W. Richardson, in his Astley Cooper prize essay on "The Cause of the Coagulation of the Blood," 1858, publishes an interesting series of experiments with lactic acid, which it will be well to refer to at some length in this connection.

He selected this acid, because, first, it is a feeble acid; second, because it is an acid of the tissues; and third, because of the theory of Dr. Prout, and others, above mentioned.

(To be continued.)

DR. E. A. MUNGER'S IMPROVED SPLINT.

BY SELDEN H. TALCOTT, M. D.

Among the recent additions to Homœopathic surgery, is a new splint for dressing fractures of the femur. It was

invented and first used by Dr. E. A. Munger, of Waterville, N. Y.

The advantages claimed for this splint are: First, simplicity; second, durability; third, readiness with which it can be made to fit any limb; fourth, facility for examining the limb at the seat of fracture without removing the dressings, and for cleansing the wound in case of a compound fracture; fifth, ease of making extension, and of regulating the amount of extension.

The advantages of this new appliance are best illustrated by a description of the splint itself.

Description.—Take an ordinary straight splint, such as is described in Liston's Practical Surgery, page 62, or Erichsen's Surgery, page 277, and fit it to the injured limb as if for application. Then saw it asunder opposite the seat of fracture, and remove an inch, or inch and a half, from each section of the splint at the point where sawn through. To the outer edges of the upper or body portion of the splint, screw two iron rods, each rod being three-eighths of an inch in diameter, and twelve to sixteen inches in length. These rods slide into grooves in the outer edges of the lower section, which are covered with tin to prevent displacement of the bandages. At the upper end of the lower segment is attached an iron bracket, the head of which rises an inch and a half above the splint, or, in case of a severe compound fracture, it may be elevated still more, for convenience in dressing the wound. Through the head of this bracket runs a screw, ten or twelve inches in length. The end of this screw fits into a depression in another bracket, corresponding to the first, which is attached to the upper segment. By turning this screw, the two sections of the splint are forced apart, and by this means extension is made and kept up to any desired degree. There should always be from three to five inches space between the sections when the splint is applied and extension made, to facilitate examinations and dressing of the wound.

The irons attached to this splint, as described, can be made in a short time, and at little cost, by any blacksmith; and if well made, one set will last the surgeon a life-time. They

can easily be removed from one splint and applied to another, either long or short, as the case may require.

Whenever a splint is needed, measure the person for whom it is designed, from a point opposite the nipple to three or four inches below the heel. Procure a board of this length, and four or five inches wide; notch the lower end, cut a groove for the external malleolus, bore holes in the upper end for the perineal band, and saw the splint through at the seat of fracture. Remove two or three inches from the splint where sawn through, screw on the irons, made as directed, and it is ready for use.

Application.—Each section, when made according to the foregoing directions, should be well padded, and the whole is then applied to the limb and body in the same manner as an ordinary Liston's splint, with rollers and perineal band. The latter should be made of firm cotton cloth, stuffed with curled hair, and covered with chamois skin. Some surgeons prefer rubber tubing for a perineal band. The only exception to the above method of applying the splint is that each section should be bandaged to the limb separately; and the space between the sections should not be covered by the roller, but with a light dressing independent of the rest. By this means the seat of fracture may be readily examined, and any displacement, however slight, quickly discovered and remedied. In case of a compound fracture, the wound may be cleansed as often as necessary without disturbing any other portion of the apparatus.

It is obvious that with this splint, properly applied extension may be made with great ease. Placing his thumb and finger upon the head of the screw, the surgeon, with a few turns, easily forces the limb to its natural length. This is done without the patient being troubled or annoyed, or the limb endangered, by the rude efforts of bungling, inefficient, or inexperienced assistants. If in the surgeon's absence the dressings should become loose, or the extension be insufficient, the nurse may remedy this by turning the screw, and without disturbing the bandages.

Lastly, the amount of extension is readily regulated. There are cases where full extension cannot safely be made at first. If the limb, at the seat of fracture, is badly swollen; if

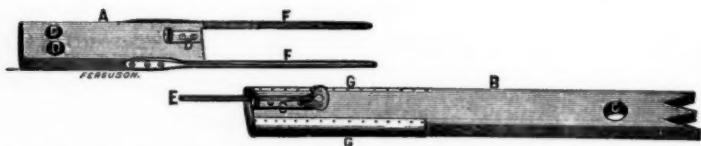
there is great nervous excitability; if the inflammation runs high; or if the muscular resistance is very great, all these obstacles may be surmounted by making the turns of the screw slow and gradual until the condition of the limb warrants a further application of power. With an appliance like this, skillfully used, the burden of care and anxiety which rests upon every surgeon who treats a fracture of the femur, is greatly lightened, the patient's sufferings much mitigated, and the danger of a shortened limb almost entirely avoided.

Case.—The case for which this splint was invented was one of uncommon interest, and one which thoroughly tested the utility of this apparatus.

Thomas R., a farmer, while loading logs, fell, and a log rolled upon his leg, causing a very oblique fracture of the femur just below the trochanter major. The upper end of the lower portion of the bone protruded through the muscles of the thigh and the integument, producing a severe lacerated wound. Dr. Munger, who was called to take charge of the case, at first applied one of Day's long splints. The wound suppurated badly, and this splint had to be removed. The patient's limb was now placed on a double inclined-plane; but with this a sufficient amount of extension could not be kept up, nor could the patient, who was unusually restless and intractable, be kept in proper position. At this juncture the new splint was conceived, made and applied. The ends of the fractured bone were now kept in close apposition, the wound could be readily dressed, and the patient could no longer get his limb out of place. The result was a rapid recovery, a perfect union of the broken bone, and a leg scarcely at all shorter than the one uninjured.

If in future trials this splint shall prove as serviceable as in the case instanced, it will become a new source of relief to unfortunate humanity, a ready helper to the enlightened surgeon, and add still further to the credit of Homœopathic surgery.

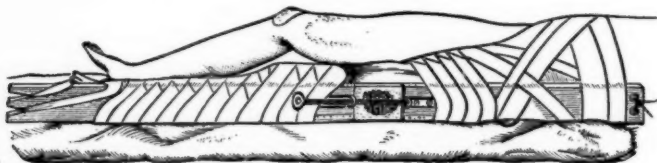
The cuts on the following page represent the splint, and show its method of application.



A Upper section. B Lower section. C Bracket through which the screw runs. D Bracket against which the screw is forced. E Screw. F Rods attached to upper portion of splint. G Grooves in lower section, covered with tin, into which the



rods slide. C (should be H) Perforation for external malleolus. D (should be I) Holes for perineal band.



Splint applied to the limb.

AN EPIGRAM.—The following is the epigram of Euricus Cordus, who died in 1535 :

"Tres medicus facies habet ; unam quando rogatus,
Angelicam ; mox est, cum juval, ipse Deus
Post ubi curato, poscit sua præmia, morbo,
Horridus apparet, terribilisque Sathan."

Which, being interpreted, reads :

"Three faces wears a doctor ; when first sought
An angel and a god's—the cure half wrought ;
But when, that cure complete, he seeks his fee,
The devil looks less terrible than he."

REPORTS OF HOSPITALS AND SOCIETIES.

Ophthalmic Hospital Reports.

**RHUS TOX. IN IRIDO-CHOROIDITIS SUPPURATIVA.
TRAUMATICA.**

BY GEO. S. NORTON, M. D.,

Resident Surgeon New York Ophthalmic Hospital.

Suppurative irido-choroiditis is one of the great dangers feared by every surgeon after severe operations on the eye, especially after cataract extraction. Sometimes the inflammatory process is confined to the iris, but more commonly involves the whole uveal tract, and often has complicated with it sloughing of the lips of the wound, and even of the whole cornea.

The symptoms of this disease, following cataract extraction, are generally very well marked.

During the first twenty-four hours, very few unpleasant symptoms are experienced, except a slight swelling of the lids, with an occasional sharp, pricking pain, owing to the accumulation of tears beneath the lids, and which is relieved by opening them and allowing the tears to escape.

If inflammation attacks the eye, the patient often passes a restless night, with attacks of nausea and vomiting, and perhaps some slight febrile symptoms.

After twenty-four or forty-eight hours, the more severe signs of iritis begin to show themselves: The patient complains of very severe pain in the eye, generally of a sharp, shooting character, extending up into the forehead, accompanied by fever, thirst, restlessness, &c.

These symptoms generally commence at night. Upon removing the bandage, the margin of the upper lid is found red, swollen, and the whole lid congested and œdematous. On opening the lids, there is a copious flow of hot tears, great chemosis of the conjunctiva, sometimes so great as to almost hide the cornea from view. These symptoms may

be all present when there is only suppuration of the lips of the wound, but this usually extends to the iris and choroid.

At a later period the lips become more swollen, harder, and tender to touch. This swelling is often so extensive that it is almost impossible to open the lids. If this can be done, and the cornea remains transparent, the iris will be found discolored, its fibrillæ become thick and swollen, the pupil contracted and sluggish, on account of the exudation into its stroma; from the edge of the pupil are first noticed little beads of exudation; afterwards, the whole anterior surface of the iris becomes covered with a thin creamy film, varying in appearance according to the extent of the exudation; this soon becomes diffused through the aqueous, giving it a hazy look; flakes of this purulent lymph are seen floating in the aqueous, which settle to the bottom of the anterior chamber, causing hypopyon.

This suppurative inflammation extends to the ciliary body, and from thence to the choroid, with similar symptoms to those already mentioned, in the iris: namely, exudation into the vitreous, detachment of the retina, etc. The pain continues all the time, only is more of a throbbing, dull character as the disease advances. The tension is at first increased, but afterwards diminished.

This increases to Panophthalmitis, or complete disorganization of all the tissues of the eye, and ends in atrophy of the ball.

This is the most common course of the disease, if it is allowed to go on unchecked, although there are many deviations from it.

Rhus tox. is a remedy that has hitherto been used very little in this form of inflammation, but, upon looking over its symptomatology, it is readily seen how closely it resembles the first stage of suppurative iritis, and it is especially in this stage that rhus has proved such a valuable remedy. The symptoms are as follows: *Lids red, swollen and edematous, especially the upper, and spasmodically closed, with profuse gushes of hot tears on opening them; sac-like swelling of the conjunctiva; yellow purulent mucus discharge; swelling around the eyes. Burning pain in eye, with much photophobia; stitches in eyes and temples, with vertigo and*

photophobia; lids cannot be opened; worse in the evening. Pain in the right eye, so severe he could not bear the slightest touch, with pressing burning pain in the eye. Child lies constantly on the face, with its hands to the head; head hot and face red, with a rhus eruption. Accompanying these symptoms, we often have the rhus pains, relieved by motion, aggravated by damp weather, and on getting wet; sensitiveness to change of temperature; also the restlessness at night, especially after midnight; disturbed by bad dreams, &c.

This remedy has proved of great value in every case of suppurative iritis following cataract extraction occurring in this Hospital, when administered in the first stage. I will only relate two cases that have come under my observation recently:

CASE I.—Mr. S., age sixty-six, rheumatic temperament. Had a cataract removed by Græfe's modified linear extraction. Upon making the iridectomy, the anterior chamber partially filled with blood, so that the iris was wounded while extracting the lens. The second night following the operation, he was attacked with sharp pains in the eye, was very restless, with some fever and thirst. Upon removing the bandage, the upper lid was found œdematously swollen, and the lids tightly closed. On opening them, a profuse gush of hot tears took place; there was chemosis of the conjunctiva, and haziness of the aqueous. Suppuration of the lips of the wound had begun. The patient was subject to rheumatism, worse in damp weather, relieved by motion.

Rhus²⁰ was administered, in water, which controlled the inflammation in a very short time. The patient made a speedy recovery, under this remedy alone.

CASE II.—Miss D., age eighteen. Had dissection made of the capsule remaining after cataract extraction. The capsule was found to be very strong, so that some force was necessary in dividing it. The following evening, was taken with nausea and vomiting. About 1 A. M. commenced having sharp, shooting pains in the eye. This continued till 3 A. M., when I was called. Upon removing the bandage, found the lids œdematous, especially the upper, and spasmodically closed. On opening them, there was a profuse and hot lachrymation, much photophobia, and some chemosis of the

conjunctiva. Gave rhus³⁰, and used a drop of atropine solution (four grs. to the ounce). The next morning, found a slight change for the better; pain was relieved, but the other symptoms remained about the same. Gave rhus³⁰⁰. In the afternoon there was very slight swelling of the upper lid, no chemosis of conjunctiva, only some redness remaining, no pain. Continued the rhus, and in a few days the patient had completely recovered from the attack.

I have also found rhus to be a remedy of great importance in cases of rheumatic ophthalmia, various forms of keratitis, and iritis, with the above symptoms; especially when there is great œdema and spasmodic closure of the lids, from which, when opened, there is a profuse discharge of hot tears.

FATAL OTORRHOEA.

BY HENRY C. HOUGHTON, M. D.

One would suppose, from the lightness with which the subject is treated, that suppurative otitis was a matter of the slightest importance. Indeed, there still remains in the public mind an impression worthy of past ages, an impression that the profession has helped to foster rather than remove. Hence, a discharge from the ear has come to be a thing solicited, when pain occurs there; a cause for congratulation when established; and a cessation of purulent secretion calls up visions of fatal results to be apprehended in any or all parts of the system. So general is this impression among the laity, that almost every case of suppurative otitis is presented with the inquiry, "Doctor, is there no danger if the discharge stops?" That the belief is general among the profession, that this class of diseases is not amenable to treatment, is shown by the following, from Dr. Roosa's paper in the *American Journal of Medical Sciences*, April, 1871: "As evidence of the skeptical state of the profession in regard to aural therapeutics, I may advance the Boylston prize question for 1870: 'Criticisms on the recent opinions of a medical writer, that the less serious diseases of the ear may be successfully treated

by a well qualified general practitioner, and the more serious affections by none.' Also the fact that distinguished practitioners have, even within a few months, seriously advised patients to stop a course of treatment for suppuration in the ears, on the general ground that it is not 'best to meddle with the ear;'—and this without any examination of the cases, and with an expressed confidence in the practitioner who had charge of them."

That suppurative otitis is a grave matter in any case, is shown by the increasing evidence gained from post mortem examinations recently made, as well as by fatal results in cases in which no autopsy has been allowed.

I have had opportunity to observe two fatal cases, one resulting undoubtedly from thrombi, ending in gangrene of right side of throat, exhaustion, coma, death. The specimen has unfortunately been lost, hence I write from memory. The temporal bone was carious to a considerable extent, toward the mastoid cells, about the inner and upper wall and floor of the tympanum; and the suppurative inflammation had involved by continuity the I. J. vein, causing phlebitis. The patient was a scrofulous child, and possibly arrest of osseous development at the carious portion complicated the case.

The other fatal case occurred in the practice of Miles W. Palmer, M. D., to whom I am indebted for these items:

Miss C. D., aged twelve. Had suffered for eight years from suppurative otitis (L). Advised by the former physician "not to meddle with the ears." On Saturday, Nov. 16th, was taken with severe earache, feverish, discharge same as usual. Aconite, bella. Nov. 17th, relieved of both fever and pain. Nov. 18th, sent for. Pain in ear and head. Fever more severe. Bella. and gels. Relieved during the day; worse at night. Continued bella. and gels. Nov. 19th, much the same. Restless night. Nov. 20th, mother thought she had a slight convulsion. Pain in ear continued. About 4 P. M. I saw the patient. She appeared very ill, face pale, anxious look, with vesicular eruption on lips and about the mouth; surface hot, pulse 120; intense headache; averse to any motion of head; discharge from ear same as usual; no tenderness or swelling of mastoid process. Advised capsicum. Bella. and caps. given in alt. Nov. 21st, better; no pain

in ear; headache less; pulse 100; temp. 103 deg. Prognosis guarded. In the evening worse. Changed to bella. and silica. Nov. 22d, worse, as regards head. Bella. and gels. P. M., pulse 90 to 96; temp. 102 deg. Head better; lower dorsal and upper lumbar region sensitive to pressure and painful on motion. Bella. and phosph. Nov. 23d, head symptoms aggravated, but spine less sensitive; temp. 100 deg.; pulse 84; better night. Nov. 24th, head still worse; photophobia, and double vision. Nov. 25th, very prostrate; intense pain in back; photophobia less; pulse 110; temp. 103.5 deg. Bella. and rhus. Nov. 26th, reported better. Same remedies. Nov. 27th, head worse; temp. 101.5 deg.; pulse feeble and less frequent; prostration. Nov. 28th, strabismus noticed first in the morning; afternoon, stupor; slight tonic convulsions just before death, which occurred at 7:25 P. M. Post mortem examination promised, but later refused.

When I saw this case, on the afternoon of the fifth day, I felt certain that pus existed in the ear, tympanum and mastoid cells; but the absence of tenderness or swelling in the region of the mastoid process, as also the general condition of the patient, precluded the operation for opening the mastoid cells by trephine, or free incisions if the tissues were softened; capsicum³⁰ was advised, from clinical knowledge of its control of chronic sup. otitis cases. The relief that followed was prompt and permanent, so far as regards the pain in the ear. The fact that the relief was followed by increased inflammation in the meninges of the dorsal and lumbar regions, raises questions which an autopsy would undoubtedly have answered, as well as those concerning the condition of the temporal bone, and the meninges of the brain. My belief is that the otitis was the exciting cause of the meningeal inflammation. This being more or less intense, as cerebral or spinal, as gels. or rhus. was given. In this connection I wish to cite five fatal cases, as reported by J. Orme Green, M. D., of Boston, in the *Transactions of the American Otological Society* for 1871:

CASE I.—B., a peddler, age twenty-eight; for two years paralysis of right side of face. May 12, 1869. From this date to May 26, symptoms became more grave till he died. Autopsy secured, and a full description of the appearance of the

petrous bones is given, with this conclusion. From these facts the source of the brain disease can be distinctly traced. From ulceration of the membrane around the stapes, the purulent matter of a chronic inflammation of the tympanum had penetrated the vestibule, and from here, running along the only two passages communicating with the interior of the skull, had emerged at the aqueductus vestibuli and meatus internus, and thus set up a fatal meningitis. A portion of the infecting matter had also probably run along the auditory nerve. The first symptoms in the case, aside from the otorrhœa of two years standing, were paralysis of the facial nerve, on the affected side, followed by constant dizziness, nausea, vomiting, and severe pain referred to the whole side of the head. After several days the vomiting ceased. The severe pain in the head could not be relieved by any remedies. The right hypoglossal nerve became paralyzed. The last two days he was delirious, and died on the twenty-fourth day from the beginning of the head symptoms.

CASE II. G. H. W., æt. twenty-two, negro, April 13, 1869; superficial scalds on the scalp and face. Three days later, discharges from ear. On examination, acute purulent inflammation, with perforation of M. T. May 13, he was discharged; perforation nearly healed; discharges ceased; hearing improved. May 15, returned. On day of discharge he laid on damp ground; took cold; intense inflammation resulted; polypus, which was removed; and, on June 2d, ordered to report as an out patient. Not seen till Nov. 23d. Gave this history: Slight discharges, till two weeks ago. Severe pain in ear, and swelling in front of tragus, which was increasing. He had now severe pain in ear, over right side of face and head, difficult deglutition, and headache; moderate discharge of pus; polypus. The polypus and bone were removed; bone felt through granulation; swelling incised, but no pus found. Under treatment, the case went on, graver conditions resulting—paralysis of right hypoglossal nerve, vertigo, epistaxis, obscured vision—till, on 30th Jan., coma and death. Autopsy revealed general inflammation of meninges of the brain, and from the arachnoid a morbid growth like granulation, involving the ninth, tenth and eleventh nerves. A similar mass filled nearly the whole

of the middle fossa of the skull. It arose from the dura mater, and extended through foramen ovale, carotid foramen, and foramen rotundum, to the outside of the skull. The vestibule, cochlea, and semicircular canals were filled with a red, solid flesh-like mass; the mastoid cells with pus; the cavity of the tympanum with much thick pus. No trace of ossicula. A polypus extended from the cavity to the meatus externus, attached to the promontory. The whole meatus ext. was carious, nearly the whole of the anterior wall had disappeared, the whole denuded of periosteum. After maceration of the bone, the extent of caries was better seen. The entire osseous meatus externus was carious, temporal bone carious to the extent of one-half inch around the meatus; roots of zygoma carious; glenoid cavity, superior surface of petrous portion of wall and lateral sinus, entrance of aqueductus vestibuli, all showing loss from caries; walls of carotid canal carious. The entire floor of tympanic cavity had been destroyed by caries, and no traces of jugular fossa existed. The growth from dura mater was examined, and found to be of high organization, considered to be the result of inflammation.

Cases III. and IV. presented similar histories, the first with perforation of the mas. cells. First seen May 27, 1870, died, in general convulsions, Sept. 4, 1870. The second had also had abscess form in mas. cells, and perforation result. First seen April 7, 1870, failed rapidly, and died comatose, without vomiting, convulsions or paralysis, April 26, 1870. No autopsy in either case.

CASE V.—Man, age twenty-five; subject to catarrh, scrofulous. Had "abscess of the ear," as he called it, two years. Deaf in both ears, so extreme that he was obliged to communicate in writing. Two months before his death he consulted Dr. H. Clarke, of Worcester, Mass. Shortly after, he showed cerebral symptoms, dizziness, headache, double vision, paralysis. He died comatose, and a collection of pus was found just over a carious spot communicating with the tympanum. On opening the bone, a sinus was found through the bony wall of the meatus above, communicating with the meatus externally, and passing backward and inward to a cavity in the cancellated structure of the mastoid pro-

cess. The roof of bone over this was gone, leaving direct communication with the cerebral tissues. The mem. tymp. was entire, and of normal appearance, apparently healthy.

This case is remarkable, from the fact that the carious cavity communicated with the meatus externus, and with the cavity of the brain, but left the membrana tympani uninjured. Dr. G. mentions a case of Troltsch, in which suppurative inflammation of the tympanum extended to the meninges by opening roof, leaving the membrane entire. But this differs from that of Troltsch, in that the membrane, during life, would have given very little, if any, indication of the serious nature of the condition existing above the tympanum.

In the same volume in which these cases are presented, is one of "abscess of the cerebellum, following a blow on a diseased mastoid process, by W. W. Moreland, M. D., Boston, Mass. The boy, age five and a half, was first seen by Dr. M. March, 1864. Had had suppuration in left ear for two years, in consequence of scarlet fever. *The physician advised that nothing be done for the trouble in the ear.* An abscess formed over the mas. proc., and carious bone was removed. Seen through the year 1864, and occasionally during 1866, 1867. In Dec., 1868, exposure to cold caused aggravation, and more bone was removed. June 15, 1869, another abscess. 1870, discharge ceased; membrane nearly gone. He did well till April, 1871, when he received a blow on the mas. proc. An abscess formed; free evacuation of pus followed, and he improved. May 7, 1871, had gastric disturbance, from improper food. The attack was slight, but on the 16th he was much worse. Delirium set in; convulsions, strabismus; no pain except frontal headache; pulse 100. These conditions continued till the pulse slackened to 60, the day before his death, which occurred May 25, 1871. The autopsy revealed extensive caries of the mas. proc., a mere shell remaining; and a probe could be passed from the seat of the meningeal inflammation, through the necrosed mastoid, out the opening of the abscess.

In *The Practitioner*, for March, 1872, John Wilkins, F. R. C. S., reports two cases of acute suppurative inflammation of the mastoid cells. The first case, caused by cold, became rapidly of severe type. The first relief was obtained

by paracentesis of the left membrane, but the amount of pus evacuated was very slight, and the features of the case grew more and more grave, till, on the fourth night, the patient's symptoms became alarming. The pain was intense; giddy, incoherent; the mastoid region tumified, sensitive to the slightest touch, yet no sign of pus. It was evident that a fatal issue must soon be reached, and Dr. W. proceeded to incise the tissues by carrying a strong scalpel, with steady pressure, through integument and bone, into the cavity of the mastoid cells, and a free flow of thick, fetid pus followed. The wound continued to ooze for four weeks; the discharge from meatus kept up two weeks. The patient made a good recovery, and at the end of nine months the hearing was perfect. The memb. tym. showed the line of incision by a white, thread-like appearance. The mastoid process was as firm as ever, and no pain resulted from a blow upon it.

The second case was a married woman, aged twenty-five. The latter part of Oct., 1870, she took cold in the head; pain set up in left ear. After about a week of severe suffering, discharge followed, which relieved for a time. Pain then came in paroxysms, better during the day, worse when warm in bed. Nov. 14, on clearing the meatus, the walls were found sodden and sensitive, the membrane perforated, the tissues over the mas. proc. congested, pressure on which caused pain to increase. The treatment, till Dec. 10, consisted in the use of poppy poultice on the part, with large doses of chloral; later, free incision to the bone; till, on the above date, Dr. W. was called. Patient delirious; pulse 140; pain intense, deep, and throbbing. Feeling that pus must be pent up in the mastoid cells and tympanum, he passed a strong scalpel through the previous wound, into and opening the cells. A small amount of black, offensive matter followed. The poultice was renewed, chloral given, and in twenty-four hours the pain had entirely subsided. The discharge continued till the end of January. Two months later, there was no destruction of bone, the membrana tympani had healed, and the hearing was normal.

Two cases have just come under my care, in which a very unfavorable prognosis has been given. One, from a recent cold, had suppurative inflammation of the tympanum.

Facial paralysis followed, and for a number of days before the last prescription, dizziness, headache, and a benumbed sensation, had been the constant symptoms. The grave nature of the case was pressed upon the patient, but with little success, and he left the hospital, to receive a second series of blisters on mastoid proc., the first having failed to relieve. I shall endeavor to follow the case, to secure future history. The second is one of extensive necrosis of the right temporal bone, of eight years' standing, the mastoid process having been perforated at two different times, low down and high up; and at the time she applied for relief, a third abscess broke in front of the auricle, just above the articulation of the jaw. Silicea⁹⁰ has relieved the patient very much, but both herself and husband refuse to allow an operation for the removal of the necrosed portion. The fatal result is only a question of time, unless removal of the dead tissue, and remedies, relieve.

That fatal results may come from necrosis, induced by purulent otitis, has long been admitted; but that death may result from this disease, in acute cases, and those in which the bone is not involved, is not so widely known. The dissections of the temporal bone show that the brain is much more liable to be affected by acute as well as chronic supuration, than has been usually accepted. Troltsch says: "Not only the true diplœ, but the bone of the os temporis in general, is in direct communication, by means of its blood-vessels, with the dura mater on the one hand, and with the soft parts of the ear on the other. The temporal bone in general receives its vessels from within and from without, and also sends them in both directions, not only to the dura mater, but also to the membranes lining the outer and middle ear. Diseases of the latter produce abnormal conditions in the bone and the vessels, which, either through the contents, or along the tissue of the walls, of the blood-vessels, pass into the dura mater, and there call up secondary pathological processes. These announce themselves, in the one case, as purulent inflammations of the brain membranes, or of the walls of the sinuses; in another, by clot formation, and closure of the caliber of the vessels, or by entrance of putrid matter into the circulation. That all these processes developing themselves

within or on the vessels, can be produced by purulent inflammation of the soft parts of the ear, without the existence of a 'caries of the petrous bone,' cannot often enough be impressed upon the practitioner, since many are inclined to fear only a 'caries of the petrous bone,' not, however, a simple otorrhœa or purulent inflammation of the soft parts of the ear."

Weightier authority on this subject cannot be quoted, and when the practitioner ceases to deal with "simple otorrhœa" as a slight matter, and these cases receive the attention they demand, we shall find fewer cases of failure of hearing in adult life or old age. Purulent discharge means mischief, more or less extensive, even if these fatal results do not follow. That it yields to homœopathic remedies, I hope to show at some other time.

CYSTICERCUS IN THE VITREOUS.

BERLIN, Dec. 9, 1872.

My dear Doctor :

When we consider the comparative rarity of this disease, there is a degree of interest attached to the unexplained frequency with which it is found here in Berlin. During the last three months, I have had the opportunity of seeing eight different cases of cysticercus in the deeper tissues of the eye.

In a conversation with a gentleman who spent the most of last year in attendance upon the eye clinics at Vienna, he informed me that, during all that time, he did not see a single case of this interesting complaint.

As yet I have heard no theory advanced to explain why it should occur with so much more frequency in this particular locality than in any other.

Two of these cases were operated upon after the method of Von Græfe—by removing the lens, and thus entering the chamber of the vitreous, and endeavoring to extract the entozoon in this manner. In both cases, doubt seemed to shadow the result.

J. A. C.

INVENTIVE GENIUS EXTRAORDINARY.

BY E. J. WHITNEY, M. D.

100 Lafayette Ave., Brooklyn, N. Y.

In perusing the pages of the *North American Journal of Homœopathy*, for the month of February, I saw an article, written by F. Seeger, M. D., of New York City, entitled "Laryngoscopic Apparatus, as Perfected and Improved," although by what process a *perfection* can be improved does not appear. In this article, which is mainly descriptive, the writer claims as his own, certain mechanical improvements pertaining to Tobold's Laryngoscope, and illustrates the same with cuts, the different portions of which are methodically labeled *a, b, c, &c., &c.* With all the enthusiasm of a newly fledged parent, exhibiting the wonderful precocity of his child, does the Doctor so descant upon the merits of his "original" invention, that poor old Tobold is thrown completely in the shade. Dr. Seeger claims to have invented two improvements upon Tobold's apparatus, viz.: First, an adaptation of its several parts, so that, as before they moved separately, and with some inconvenience to the operator, they now move together, by the action of *one* set screw instead of three. Second, a pendant mirror, or reflector, which moves with the condenser (being fastened to it), and, from its position, less likely to be in the way of the hand.

I charge that Dr. Seeger, in claiming for himself the authorship of these improvements, does so in the full knowledge that an apparatus embodying *all* to which he lays claim, has been in existence for some years. The improvements in question are *my own*, and were copied by Dr. Seeger, almost exactly, from an instrument, which he saw in use at the Brooklyn Homœopathic Dispensary, in the fall of 1871. The following is submitted as a correct account of the matter from its beginning:

Some time during the month of November, 1871, Dr. Seeger called at the Brooklyn Homœopathic Dispensary, where I was engaged, and invited me to deliver a lecture upon Laryngoscopy, at the Clinical Hospital in New York. While there, I showed him my improved laryngoscope, and explained its ad-

vantages over the old "Tobold" apparatus, the Doctor expressing his approval. During one of the spring months following, happening in at Tiemann's (surgical instrument maker), I was shown by Mr. Stohlmann a laryngoscope embodying all my improvements, he at the same time stating that the originator of said improvements was Dr. Seeger. I at once addressed a note to the Doctor, asking him to correct the false impression under which Mr. S. was evidently laboring, to which he replied as follows :

157 E. 56TH STREET, NEW YORK, May 11, 1872.

My Dear Sir: Your favor is hereby acknowledged. I am sorry you can't see the case referred to.

The most remarkable portion, however, of your letter, is that in which you request me to inform Tiemann that certain improvements in "Tobold's Laryngoscopic Apparatus" (at which I have been engaged for a long time), are not mine, *but yours*. You refer to my having seen these improvements in your office at the Brooklyn Dispensary last fall, where I visited. It is perfectly true that you showed me something, but what particular qualities of superiority you claimed, I cannot say that I recalled. I have an indistinct remembrance of a clumsy looking tin (I believe it was tin, but am not positive) barrel, enclosing the brass tube of the apparatus. At what may be termed the distal extremity of this tube, you had an immovable attachment for the reflector. Now, whilst you may perhaps claim that this is an improvement, and while my recollection is that, as a matter of courtesy, I praised your improvements, I have positive evidence to show that I had spoken to Tiemann of my proposed improvements *before* I made my visit to the Brooklyn Homœopathic Dispensary, and *before* I knew of any improvements by you. If you can show me where I have gained a single idea *from you*, which I did not possess before this meeting at the Dispensary, as a matter of justice and right it will be my duty to withdraw my claims; but until you do so, I shall continue to claim what you have seen at Mr. Tiemann's.

Yours very respectfully,

(Signed) F. SEEGER.

Being satisfied, from the tenor of this note, that Dr. S. was determined to "brazen" it through, I addressed the following to him, which to this day remains unanswered :

100 LAFAYETTE AVE., BROOKLYN, May 18, 1872.

My Dear Sir: I am sorry to be obliged to enter into controversy with a professional brother upon any subject, and all the more so in the present instance, from the fact that it is more or less of a personal character; but in the matter under dispute, you are so positive and tenacious upon a point which is so manifestly unjust to myself, that I reluctantly accept the issue, and hope, by a calm and dispassionate array of facts, to convince you that the position you have assumed is untenable.

In the first place, the improvement upon Tobold's laryngoscope does not relate in any way to its power of illumination, or construction and arrangement of the lenses, but merely harmonizes the apparatus, so that it may be used with less trouble and inconvenience; or in other words, where, in the "old Tobold," the mirror, condenser, and light move separately, and without connection, they are now so blended as to

move altogether, by one motion, up or down the perpendicular rod, according to the desired height. This is *all* that the instrument I saw at Mr. Tiemann's accomplished, and that being the case, your claim of the aforesaid improvements must fall to the ground, and I need only refer to your own *admissions* to prove my case. When you visited me, at the Brooklyn Homœopathic Dispensary, I showed you the apparatus in use there, and explained its superiority over the Tobold. But while you recollect that, as a "matter of *courtesy*, you praised my improvement" (thereby recognizing it), you hold that, inasmuch as *before* this date you had spoken to Mr. Tiemann of your *proposed* improvements—and previous to your knowledge of any such improvements by me—you hold, I repeat, that the full knowledge of an instrument, embodying just the improvement you now claim, which *already existed*, and was being used, and was a *bona fide* production, does not invalidate your *visionary* laryngoscope, which only became a *reality* after a lapse of nearly *eight months*. But, as this point may not be sufficiently strong, and the more effectually to disabuse you of the error into which you have fallen, I will state, that three years ago this early summer, I had made for me an instrument embodying all the innovations you claim, of which the one at the Dispensary is almost a facsimile. This instrument was made by a Mr. Prosch, 150 Chatham street, N. Y., and I superintended its construction, by models and drawings, until its completion. This, like its fellow, was made of brass (no tin entering into the construction of either), in the best manner, by a thorough mechanic, while the lenses were ground in an adjoining room. It was publicly exhibited at Dr. Ruppner's dispensary, nearly two years ago, while the *mate* to the one you saw has been on exhibition at a prominent optician's, on Broadway, nearly all winter. I care not how long you may have contemplated these improvements to which you lay claim, nor does it matter whether you remembered the salient points of the instrument you saw; nor is it of any importance, as far as the question at issue is concerned, whether or no you *ever* saw it; the fact that my laryngoscope, embodying all the improvements you claim as your own, was already in existence, with a priority of nearly three years, can be proved by evidence which cannot be controverted, and your logic falls helpless by its own inherent weakness.

But it is unnecessary for me to write further. What I *have* written has been from a spirit of kindness, rather than anger, for I cannot believe you guilty, nor do I accuse you, of *plagiarism*. But it *must* now be plain to your mind that your claim of originality in the apparatus of your own will not bear a moment's scrutiny from a disinterested standpoint; and I sincerely hope, "as a matter of justice and right," that you will consider it your duty to withdraw your claim.

Yours, respectfully,

(Signed) E. J. WHITNEY.

Learning that it was his intention to bring his pretentious claims before the American Institute, I furnished Dr. R. C. Moffat, of this city—one of the delegates—a copy of the above correspondence; but the absence of Dr. Seeger happily (for him) averted his exposure before that body. Prior to my departure for Europe last June, fearing that advantage might be taken during my absence, the same correspondence was placed in the hands of my friend Dr. Wm. Tod Helmuth, of New York, who was instructed to publish the same should

Dr. Seeger's bogus claims be advanced. So much for Dr. Seeger. Now a few words for myself.

I have already stated that the improvements claimed by him have a priority in *my* favor, of *several years*, and I present the following statement in confirmation of this assertion :

-150 CHATHAM STREET, NEW YORK, Feb. 11, 1873.

I hereby certify that during the summer of 1870, I manufactured for, and under the instruction of, Dr. E. J. Whitney, a laryngoscope having certain improvements over the one given me as a model (Tobold's). These improvements consisted in uniting the laryngoscope to gas-arm, and having attached to the opposite end a movable reflector, which hung perpendicularly in front of the object-glass, the whole being worked by one thumb-screw, instead of (as formerly) three.

(Signed) ANDREW PROSCH.

I now leave this question to be judged by the profession, according to the evidence. Dr. Seeger stands convicted—in the light of the facts stated in this article—of arrogating to himself credit of originality to which he has no claim, and *must know* such to be the case. He doubtless flatters himself that he may be able, in boldly claiming the invention of another, and escaping detection, to achieve a medical fame he might never otherwise attain. This may be *his* road to success, but he has yet to realize the unmanliness of an act, which, under the guise of originality, deliberately filches the result of another's thought, and labor

DR. VON MOSETIG cured a double aneurism of the left lower extremity, by intermittent digital compression. First day, twice, four minutes and five minutes; 2d day, three times, five minutes each time; 3d day, ten minutes each, three times; 4th and 5th days, the same; 6th day, ten minutes once, and twelve minutes twice; 7th day, for forty-five minutes, divided in three intervals; 8th day, fifteen minutes, twice; 9th day, thirty-one minutes; 10th day, thirty-five minutes; 11th day, thirty-seven minutes; 12th day, forty-one minutes. At the 12th day, the total coagulation, with entire cessation of pulsation, was shown, without the slightest disturbance of circulation.

The New York Journal of Homœopathy.

NEW YORK, MARCH 1, 1873.

WM. TOD HELMUTH, M. D., AND T. F. ALLEN, M. D.,
Editorial Committee.

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To insure publication, Communications should be *brief, practical*, and carefully written, on one side of the page.

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CARLE & GRENER, No. 25 Broad Street, New York.

In issuing THE NEW YORK JOURNAL OF HOMŒOPATHY, those interested in its welfare feel the responsibility they have assumed. The establishment, however, in this metropolis, of a monthly periodical devoted to the interests of Homœopathy, has been long under consideration, and has for some time past been demanded by the profession throughout the country.

Our old Quarterly, *The North American*, holds—as it has done for years past—the even tenor of its way, its worth appreciated and its labors successful—perhaps more so at the present, than at any previous time of its existence. It occupies, in our literature, a conspicuous position, and has its spheres of action and usefulness. Yet the number of hospitals, dispensaries, infirmaries, colleges, homes for the aged and infirm, houses for the shelter and education of the orphan and the foundling, which are now placed under our charge; the numbers of competent and educated physicians by whom we are surrounded; together with the daily advancement in

all departments of medical and surgical science, offer inducements for the publication of a *monthly* periodical which, we conceive, should not at the present be overlooked.

The Faculty of the New York Homœopathic Medical College, viewing the matter from such a stand-point, have, after due deliberation, deemed the establishment of such a serial both necessary and proper.

The tone of this journal shall be liberal in every respect. It solicits contributions from scientific men. Its pages are open for fair and unbiased controversy. It has opinions and principles of its own to enunciate and defend, and it freely allows such privilege to others. It is not established to afford opportunity for members of any clique to *puff* themselves, or their ideas, or their methods of treatment, their operations, or their newly invented instruments; nor will its pages be open to interchanges of those *personalities* which, in the majority of instances, make such a lamentable *exposé* of that weak side of the profession—jealousy—which so often soils the escutcheon of both medical journals and medical societies.

Those who have assumed the editorial management, are aware of the many difficulties to be encountered, and it is not without some misgivings they enter upon the work assigned them. They trust, however, that, by a certain degree of watchfulness, they may be enabled to advance the interests of Homœopathy, and to offer to the profession an opportunity for interchange of thought and opinion.

THE DEATH OF NAPOLEON III.

Very many conflicting opinions prevail among medical men as to the immediate cause of death of the late Napoleon. A great deal has been said regarding the nature of the operation, its performance, and its repetition; and celebrated names are

found among those ready to decry the proceedings of the surgeons in attendance.

From a careful perusal of some of the published statements of these gentlemen, it appears that but little real evidence of the true nature of the death of the illustrious man can be arrived at. Quotations from text-books as to the propriety of lithority in the case, have no bearing at all, for every one knows that the rules and directions for performing any operation are for the generality of cases, and not for the special and exceptional ones, such as undoubtedly was that of the Emperor. In operations, especially about the urethra and bladder, occasionally rapid demise takes place, unlooked for, unsatisfactory, and almost unaccountable. We have known in more than one instance, death follow the simple introduction of the catheter, and no man understands such conditions more thoroughly, or describes them better, than Sir Henry Thompson himself. It is therefore scarcely fair to lay at the door of the profession, a death which, from the position of the patient, and the peculiar circumstances surrounding his residence in England at the time, the surgeons would certainly have done everything to prevent. A still more unfair and contemptible inuendo, it appears, has gained credence, and one which tends to throw such discredit upon the profession that it should be at once refuted. The bare idea that Napoleon III. was sacrificed by his attendants for political purposes, is too derogatory to be entertained. ●

We give below a portion of the official report of the autopsy, that each of our readers may form his own opinion on the case:

The most important result of the examination was that the kidneys were found to be involved in the inflammatory effects produced by the irritation of the vesical calculus (which must have been in the bladder several years) to a degree which was not suspected, and if it had been supposed, could not have been ascertained. The disease of the kidneys was of two kinds: there was, on the one hand, dilation of both ureters, and of the pelvis of the kidneys; on the left the dilation was excessive, and had given rise to atrophy of the glandular substance of the organ. On the other there was sub-acute inflammation of the uriniferous tubes, which was of

more recent origin. The parts in the neighborhood of the bladder were in a healthy state; the mucous membrane of the bladder and prostatic urethra exhibited signs of sub-acute inflammation, but not the slightest indication of injury. In the interior of the bladder was found a part of a calculus, the form of which indicated that half had been removed. Besides this, there were two or three extremely small fragments, none of them larger than a hemp-seed. This half-calculus weighed about three-quarters of an ounce, and measured $1\frac{1}{2}$ by 1.5-1.6 of an inch. There was no disease of the heart, nor of any other organ, excepting of the kidneys. The brain and its membranes were in a perfectly natural state. The blood was generally liquid, and contained only a very few small clots. No trace of obstruction by coagula could be found, in the venous system, in the heart, or in the pulmonary artery. Death took place by failure of the circulation, and was attributed to the general constitutional state of the patient. The disease of the kidneys—of which this state was the expression—was of such a nature, and so advanced, that it would in any case have shortly determined a fatal result.

Signed by all present,

J. BURDON SANDERSON, M. D.

Dr. CONNEAU.

Dr. LE BARON CORVISART.

HENRY THOMPSON.

J. T. CLOVER.

JOHN FOSTER.

CAMDEN PLACE, CHISELHURST, JAN. 10, 1873—6.30 P. M.

NOTICE.—Owing to want of space, several interesting articles have been excluded from the present number of this Journal. Our "Foreign Notes" and "Correspondence" have shared the same fate.

It is the intention of those interested in this publication, to enlarge the same, if sufficient encouragement is obtained from our friends throughout the country.

We solicit contributions from all Homœopathic physicians, and hope to place upon our exchange list the best periodicals, both of home and foreign publications. Reports of our College commencements, with a full list of graduates, are especially desired, as are notices of removals of physicians, and records of interesting medical and surgical cases.